

DATE OF INTERVIEW
MONTH DAY YEAR

INTERVIEWER ID #

MEDICATIONS SUPPLEMENT
SIX MONTH QUESTIONNAIRE

Card 04

ID # ¹ ³⁻⁵ FORM ⁶⁻⁷ V ⁸

9-10

ENTER RESPONSES TO C2 THROUGH C6 ON MEDICATION TABLE BELOW.

C2. Please tell me the names of all these medications. SPECIFY BRAND NAME FOR ASPIRIN AND OTHER ANALGESICS. ASK C3 THRU C6 FOR A MEDICATION BEFORE ASKING ABOUT THE NEXT MEDICATION.

C3. What was your usual dosage for (MEDICATION NAME)?

C4. How often did you take this medication?

C5. Is this a prescription medication?

C6. How many days or weeks did you take this medication during the last three months?

WHEN TABLE IS COMPLETED, PROBE: Is there any other medication you took during the past three months? IF YES, ENTER ON TABLE; IF NO, END QUESTIONNAIRE.

C2 MEDICATION NAME	C3 DOSAGE	C4 SCHEDULE	C5 PRESCRIPTION?	C6 TIME TAKEN
11-14 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	15-18 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	19 <input type="text"/> X DAY 20 <input type="text"/> X WEEK	YES.....1 NO.....2	22-23 <input type="text"/> <input type="text"/> DAYS 24-25 <input type="text"/> <input type="text"/> WEEKS
26-29 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	30-33 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	34 <input type="text"/> X DAY 35 <input type="text"/> X WEEK	YES.....1 NO.....2	37-38 <input type="text"/> <input type="text"/> DAYS 39-40 <input type="text"/> <input type="text"/> WEEKS
41-44 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	45-48 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	49 <input type="text"/> X DAY 50 <input type="text"/> X WEEK	YES.....1 NO.....2	52-53 <input type="text"/> <input type="text"/> DAYS 54-55 <input type="text"/> <input type="text"/> WEEKS
56-59 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	60-63 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	64 <input type="text"/> X DAY 65 <input type="text"/> X WEEK	YES.....1 NO.....2	67-68 <input type="text"/> <input type="text"/> DAYS 69-70 <input type="text"/> <input type="text"/> WEEKS
71-74 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	75-78 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	79 <input type="text"/> X DAY 80 <input type="text"/> X WEEK	YES.....1 NO.....2	82-83 <input type="text"/> <input type="text"/> DAYS 84-85 <input type="text"/> <input type="text"/> WEEKS
86-89 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	90-93 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	94 <input type="text"/> X DAY 95 <input type="text"/> X WEEK	YES.....1 NO.....2	97-98 <input type="text"/> <input type="text"/> DAYS 99-100 <input type="text"/> <input type="text"/> WEEKS

EARLY PREGNANCY STUDY
SIX-MONTH QUESTIONNAIRE

Card 01

ID# ¹ ^{3 - 5} FORM ^{6 - 7} V ⁸

NAME OF INTERVIEWER _____

INTERVIEWER ID ¹¹⁻¹²

DATE OF INTERVIEW ¹³⁻¹⁴ ¹⁵⁻¹⁶ ¹⁷⁻¹⁸
MONTH DAY YEAR

SECTION A. TOBACCO UPDATE

A1. Are you currently smoking cigarettes?

YES.....1
NO.....(A6).....2 19

A2. On the average day, how many cigarettes do you smoke?
(20 CIGARETTES TO A PACK)

²⁰⁻²¹

CIGS

A3. Did you smoke about (NUMBER OF CIGARETTES IN A2) cigarettes a day during the entire three month period?

YES.....(A9).....1
NO.....2 22

A4. On what date did you begin to smoke (NUMBER OF CIGARETTES IN A2) cigarettes a day?

²³⁻²⁴ ²⁵⁻²⁶ ²⁷⁻²⁸
MONTH DAY YEAR

A5. About how many cigarettes a day did you smoke before (DATE IN A4)?

SKIP TO A9.

²⁹⁻³⁰

CIGS

A6. Have you smoked any cigarettes during the past three months?

YES.....1
NO.....(A9).....2 31

A7. When did you quit smoking?

³²⁻³³ ³⁴⁻³⁵ ³⁶⁻³⁷
MONTH DAY YEAR

A8. About how many cigarettes a day did you smoke during the last three months?
(20 CIGARETTES TO A PACK)

³⁸⁻³⁹

CIGS

A9. Did you smoke any marijuana during the last three months?

YES.....1
NO.....(A11).....2 40

A10. How many times did you smoke marijuana during the last three months?

41-42
[] []
TIMES

A11. Did your (husband/partner) smoke any cigarettes during the past three months?

YES.....1
NO.....2 43

A12. In order to provide us with a computer link for all of our documents, would you please tell me your date of birth again?

44-45 46-47 48-49
[] [] [] [] [] []
MONTH DAY YEAR

SECTION B. BEVERAGE UPDATE

Now I'm going to ask you some questions about the beverages you drink. RECORD RESPONSES ON BEVERAGE TABLE BELOW. RECORD ALL INFORMATION ON EACH BEVERAGE BEFORE GOING ON TO THE NEXT BEVERAGE.

B1. During the past three months, how many (READ BEVERAGE AS SPECIFIED ON CHART) did you drink on a daily, weekly or monthly basis? IF "NONE" OR "NEVER DRINK", CODE ZERO IN NONE-FREQUENCY COLUMN ON BEVERAGE TABLE AND ASK FOR NEXT BEVERAGE. USE THE COMMENTS COLUMN FOR RESPONSES THAT DO NOT FIT THE PRECODED TABLE.

BEVERAGE TABLE

BEVERAGE	B1 FREQUENCY				COMMENTS
	NONE	DAILY	WEEKLY	MONTHLY	
cups of brewed caffeinated coffee	50	51 - 52	53 - 54	55 - 56	
cups of instant caffeinated coffee	57	58 - 59	60 - 61	62 - 63	
cups or glasses of non-herbal hot or iced tea	64	65 - 66	67 - 68	69 - 70	
Of the following soft drinks (SHOW CARD)	71	72 - 73	74 - 75	76 - 77	
12 oz. bottles or cans of beer	78	79 - 80	81 - 82	83 - 84	
4 oz. glasses of wine	85	86 - 87	88 - 89	90 - 91	
1½ oz. shots of hard liquor	92	93 - 94	95 - 96	97 - 98	

SECTION C. MEDICATIONS UPDATE

Card 02

- C1. Have you taken any prescription or non-prescription medications, including aspirin, digestive aids, vitamins or injections during the past three months?

YES.....1
NO.....(END).....2

ENTER RESPONSES TO C2 THRU C6 ON MEDICATION TABLE BELOW.

- C2. Please tell me the names of all these medications. SPECIFY BRAND NAME FOR ASPIRIN AND OTHER ANALGESICS. ASK C3 THRU C6 FOR A MEDICATION BEFORE ASKING ABOUT THE NEXT MEDICATION.

- C3. What was your usual dosage for (MEDICATION NAME)?

- C4. How often did you take this medication?

- C5. Is this a prescription medication?

- C6. How many days or weeks did you take this medication during the last three months?

WHEN TABLE IS COMPLETED, PROBE: Is there any other medication you took during the past three months? IF YES, ENTER ON TABLE; IF NO, END QUESTIONNAIRE.

C2 MEDICATION NAME	C3 DOSAGE	C4 SCHEDULE	C5 PRESCRIPTION?	C6 TIME TAKEN
12-15 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	16-19 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	20 <input type="text"/> X DAY 21 <input type="text"/> X WEEK	YES.....1 NO.....2	23-24 <input type="text"/> <input type="text"/> DAYS 25-26 <input type="text"/> <input type="text"/> WEEKS
27-30 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	31-34 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	35 <input type="text"/> X DAY 36 <input type="text"/> X WEEK	YES.....1 NO.....2 ³⁷	38-39 <input type="text"/> <input type="text"/> DAYS 40-41 <input type="text"/> <input type="text"/> WEEKS
42-45 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	46-49 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	50 <input type="text"/> X DAY 51 <input type="text"/> X WEEK	YES.....1 NO.....2 ⁵²	53-54 <input type="text"/> <input type="text"/> DAYS 55-56 <input type="text"/> <input type="text"/> WEEKS
57-60 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	61-64 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	65 <input type="text"/> X DAY 66 <input type="text"/> X WEEK	YES.....1 NO.....2 ⁶⁷	68-69 <input type="text"/> <input type="text"/> DAYS 70-71 <input type="text"/> <input type="text"/> WEEKS
72-75 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	76-79 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	80 <input type="text"/> X DAY 81 <input type="text"/> X WEEK	YES.....1 NO.....2 ⁸²	83-84 <input type="text"/> <input type="text"/> DAYS 85-86 <input type="text"/> <input type="text"/> WEEKS
87-90 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	91-94 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OFFICE CODE	95 <input type="text"/> X DAY 96 <input type="text"/> X WEEK	YES.....1 NO.....2 ⁹⁷	98-99 <input type="text"/> <input type="text"/> DAYS 100-101 <input type="text"/> <input type="text"/> WEEKS

INTERVIEWER REMARKS

03
Card 04

R1. RESPONDENT'S COOPERATION WAS

VERY GOOD.....1
 GOOD.....2
 FAIR.....3
 POOR.....4

11

R2. THE QUALITY OF EACH SECTION OF THE INTERVIEW IS: (COMPLETE FOR EACH SECTION CIRCling THE FOLLOWING CODES).

HIGH QUALITY.....1 GENERALLY RELIABLE...2 QUESTIONABLE...3
 UNSATISFACTORY...4

12

IF CODE 3 OR 4, CODE REASON, USING CODES BELOW.

	QUALITY				REASON	
SECTION A: TOBACCO.....1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	13-15
SECTION B: BEVERAGE.....1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	16-18
SECTION C: MEDICATION.....1	2	3	4	<input type="checkbox"/>	<input type="checkbox"/>	19-21

REASON CODES FOR QUESTIONABLE OR UNSATISFACTORY INFORMATION (ENTER CODE ABOVE):

THE MAIN REASON FOR UNSATISFACTORY OR QUESTIONABLE QUALITY OF INFORMATION WAS BECAUSE THE RESPONDENT:

DID NOT KNOW OR REMEMBER ENOUGH ABOUT THE TOPIC.....01
 DID NOT WANT TO BE MORE SPECIFIC.....02
 DID NOT UNDERSTAND OR SPEAK ENGLISH WELL.....03
 WAS BORED OR UNINTERESTED.....04
 WAS UPSET, DEPRESSED OR ANGRY.....05
 HAD POOR HEARING OR SPEECH.....06
 WAS CONFUSED OR DISTRACTED BY FREQUENT INTERRUPTIONS.....07
 WAS INHIBITED BY OTHERS AROUND HER.....08
 WAS EMBARRASSED BY THE SUBJECT MATTER.....09
 WAS EMOTIONALLY UNSTABLE.....10
 WAS PHYSICALLY ILL.....11
 OTHER (SPECIFY) _____...12
